ILDING NG	<u>00</u>	(X3) DATE SURVEY COMPLETED 09/19/2012
8181 H	ARCOURT RD	
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
000		
N	STREET A 8181 HA INDIAN ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260 ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

S5I211

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/01/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/19/2012	
	PROVIDER OR SUPPLIEF	RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD IAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Medicaid: 67 Other: 11 Total: 95				
	Sample: 5				
		es reflect state findings nce with 410 IAC 16.2.			
	Quality review of 20, 2012 by Bev	completed on September Faulkner, RN			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: \$51211

Facility ID: 000070

If continuation sheet Page 2 of 10

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/19/2012	
	ROVIDER OR SUPPLIER	I S RSING AND REHABILITATION	STREET A 8181 H.	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD IAPOLIS, IN 46260	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	DROUDERS N. AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
F0225 SS=D	483.13(c)(1)(ii)-(ii INVESTIGATE/R ALLEGATIONS/II The facility must in have been found neglecting, or mis court of law; or have into the State nur abuse, neglect, in misappropriation any knowledge it law against an enindicate unfitness or other facility stregistry or licensii. The facility must involving and misappropriation are reported immediate and misappropriation and misappropriation are reported immediates in accord through establish the State survey at alleged violations investigated, and potential abuse with progress. The results of all reported to the according to the scertification agent the incident, and the state incident incident, and the state incident i	ii), (c)(2) - (4) EPORT NDIVIDUALS not employ individuals who guilty of abusing, streating residents by a ave had a finding entered se aide registry concerning histreatment of residents or of their property; and report has of actions by a court of hiployee, which would for service as a nurse aide aff to the State nurse aide hig authorities. Hensure that all alleged hig mistreatment, neglect, or hinjuries of unknown source hition of resident property hediately to the he facility and to other hance with State law hed procedures (including to have evidence that all hare thoroughly hust prevent further hill the investigation is in hinvestigations must be diministrator or his sentative and to other hance with State law	TAG	DEFICIENCY)	DATE
	be taken. Based on intervi	ew and record review, the	F0225	The creation and submission of	of 09/30/2012

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Event ID: \$51211

Facility ID: 000070

If continuation sheet Page 3 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155149	B. WIN			09/19/2012	
			Б. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ARCOURT RD		
HARCOL	JRT TERRACE NU	RSING AND REHABILITATION			IAPOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	
	facility failed to	ensure an allegation of			this Plan of Correction does no		
	abuse made by a	resident was			constitue an admission by this		
	immediately rep	orted to the Administrator			provider of any consclusion see forth in the statement of	et	
		y investigations reviewed.			deficiencies, or of any violation	n of	
	(#B)	, ,			regulation.This provider		
	(112)				respectfully requests that the		
	Findings in deal				2567L Plan of Correction be		
	Findings include	ð.			considered the Letter of Credi		
					Allegation and also respectfull	У	
		Resident #B was reviewed			requests desk review of the		
	on 9/17/12 at 12	:25 p.m.			information provided herein, o after September 30, 2012.Wh		
					corrective action will be	al	
	Diagnoses inclu	ded but were not limited			accomplished for those reside	ents	
	_	glaucoma, hypertension,			found to have been affected b		
		with depressed mood and			the deficient practice?The		
	delusions.	with depressed mood and			employee was suspended		
	delusions.				immediately and then		
	TOIL .				terminated.All allegations of		
		significant change			abuse will be reported to the administrator immediately.Hov	, , , , , , , , , , , , , , , , , , ,	
		Set (MDS) Assessment,			will you identify other residents		
	dated 8/3/12, inc	dicated Resident #B was a			having the potential to be affe		
	7 out of a possib	ole 15 on the Brief			by the same deficient practice		
	Interview for M	ental Status (BIMS) for			and what corrective action will	be	
	cognition. The s	core indicated the			take?All residents have the		
	_	derately impaired in			potential to be affected. The	44-	
		MDS indicated Resident			Executive Director inserviced	tne	
	_	oort the correct day of the			staff on 9-25-12 on Abuse Prevention and Reporting with	ı a	
	_	ecalled one word with			completion date of 9-30-12.W		
	1				measures will be put into place		
cuing out of three words given to recall.				what systemic changes you w			
	The MDS indicated Resident #B was				make to ensure that the defici	ent	
	feeling down, depressed or hopeless and				practice does not recur?All		
	feeling bad about herself for 12 - 14 days				employees are educated	d-a	
	of the MDS asse	essment time frame for			regarding Abuse Prevention a	an	
	mood.				Reporting at orientation and inserviced at least bi-annually	and	
					on an ongoing basis througho		
	Δ care nlan data	d with a problem start			the year by the SDc or		
	A care plan date	a will a problem start				ĺ	

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Event ID: \$51211

Facility ID: 000070

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
155149		A. BUI B. WIN			09/19/2	2012	
		ı	D. WIN		ADDRESS, CITY, STATE, ZIP CODE	I	
NAME OF F	PROVIDER OR SUPPLIEF	R			ARCOURT RD		
HARCOL	IRT TERRACE NILL	RSING AND REHABILITATION			IAPOLIS, IN 46260		
					JEIO, III TOEOU		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	·		DATE
		indicated, "Resident has			designee.All employees have criminal history checks comple	otod	
	Psychotic Episo	des (Delusions) AEB [as			by an outside source prior to	eleu	
	evidenced by] be	elieve staff refuse to			employment, as well as		
	provide care, far	nily does not visit, and			references completed.Manage	ers	
	meds [medication	ons] are to kill her rather			are educated regarding staff		
	than help her'	-			burnout, monitoring labor hou		
	man norp nor				and meeting with staff regular		
	During an inta-	vious on 0/19/12 at 10:20			ensure communication is oper	-	
	_	view on 9/18/12 at 10:30			the E.D. on 9-23-12.QIS abus		
		istrator indicated during a			questions will be utilized every shift with employees, 7 days a		
		ent #B's progress notes on			week, x 2 weeks, and weekly		
	9/17/12 at 6:00 լ	p.m., she discovered an			weeks, and monthly thereafter		
	abuse allegation	made by the resident			and submitted to the CQI	,	
	documented in	the progress notes dated			Committee for review and follo	ow	
	9/17/12 at 3:13 i	p.m., which was entered			up to ensure all employees are		
	·	ctical Nurse [LPN] #1.			knowledgeable about identifyi		
	*	tor indicated LPN #1 left			and reporting abuse unitl 1009		
					compliance is achieved.All sta were educated on Abuse	ш	
	_	out reporting the			Prevention and Reporting		
	allegation to the	Administrator.			inservice on 9-25-12 with		
					completion date of 9-30-12.Ho	ow	
		0:45 a.m., the progress			the corrective action will be		
	notes for Reside	nt #B were re-reviewed			monitored to ensure the defici		
	after the intervie	w with the Administrator			practice will not recur, ie: what		
	regarding LPN #	#1's entry to Resident #B's			quality assurance program wil	ı be	
	record on 9/17/1				put into place?To ensure compliance, the DNS/designe	_ ie	
	322-2 022 3/17/1	F			responsible for the completion		
	A progress note	, dated 9/17/12 at 3:13			the Abuse CQI tool weekly for		
	1 0				weeks, bi-monthly for 2 month		
	_	"Resident continues to			adn then quarterly until contin	ued	
	_	tatements. States staff is			compliance is maintained for 2		
	mean and that we dont (sic) want to help				consecutive quarters. The res		
	her. Did not remember staff getting her				of these audits will be reviewe		
	up in chair today	y and toileting her. Also			by the CQI committee oversed by teh E.D. If threshold of 100		
	states she's afrai	d of staff. Comfort			is not achieved an action plan		
		red we are here to help her			be developed to ensure	*****	
		ible and rubbed resident			compliance.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/01/2012 FORM APPROVED OMB NO. 0938-0391

155149		A. BUILDING B. WING	G 00	COMPLETED 09/19/2012			
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) back."	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	(X5) COMPLETION DATE			
	A facility investigation provided by the Administrator on 9/18/12 at 2:30 p.m., with an incident date of 9/17/12 at 6:00 p.m., indicated, "Brief Description of Incident: ED [Executive Director] viewing daily nursing documentation and found statement from resident within nurses note stating that staff was mean to her and that they don't want to help her and that she was afraid of staff" The investigation indicated Certified Nursing Assistant [CNA] #2 was in the room with Resident #B when she made the statements that LPN #1 recorded in the progress notes dated 9/17/12 at 3:13 p.m. A typed interview with CNA #2, dated 9/18/12, and initialed by the Administrator indicated, "I asked [name of CNA #2] what she thought the statements from [name of Resident #B] could be, and she stated abuse and that the nurse was there"						

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Event ID: \$51211

Facility ID: 000070

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED	
		155149	B. WIN	G		09/19/2012	
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION			•	8181 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD APOLIS, IN 46260		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	DROWING BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0226 SS=D	ETC POLICIES The facility must of written policies are mistreatment, negresidents and mister property. Based on interviolation facility failed to policy was impless a Licensed Pract	develop and implement and procedures that prohibit glect, and abuse of sappropriation of resident ew and record review, the ensure the facility abuse emented as evidenced by ical Nurse did not	F02	26	What corrective action will be accomplished for those resider found to have been affected by the deficient practice?The employee was suspended		09/30/2012
	made by a reside for 1 of 4 facility (#B) Findings include	esident #B was reviewed			immediately and then terminated.All allegations of abuse will be reported to the administrator immediately.How will you identify other residents having the potential to be affect by the same deficient practice and what corrective action will take?All residents have the potential to be affected.The Executive Director inserviced to staff on 9-25-12 on Abuse	cted be	
	to osteoporosis, a senile dementia of delusions. The most recent Minimum Data Stated 8/3/12 india 7 out of a possib Interview for Me cognition. The so resident was moothed.	ded but were not limited glaucoma, hypertension, with depressed mood and significant change Set (MDS) Assessment scated Resident #B was a le 15 on the Brief ental Status (BIMS) for core indicated the derately impaired in MDS indicated Resident			Prevention and Reporting with completion date of 9-30-12.Wh measures will be put into place what systemic changes you wi make to ensure that the deficie practice does not recur?All employees are educated regarding Abuse Prevention and inserviced at least bi-annually on an ongoing basis throughouthe year by the SDc or designee.All employees have criminal history checks comple by an outside source prior to employment, as well as references completed.Manage	nat e or II ent dn and ut	

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Event ID: \$51211

Facility ID: 000070

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[· ·		(X2) M	IULTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	COMPLETED	
		155149	B. WIN	NG		09/19/2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
					ARCOURT RD	
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION		INDIAN	APOLIS, IN 46260	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
		ort the correct day of the			are educated regarding staff burnout, monitoring labor hour	700
	_	ecalled one word with			and meeting with staff regular	
	_	e words given to recall.			ensure communication is oper	
	The MDS indica	ted Resident #B was			the E.D. on 9-23-12.QIS abuse	e
	feeling down, de	pressed or hopeless and			questions will be utilized every	•
	feeling bad abou	t herself for 12 - 14 days			shift with employees, 7 days a	
	of the MDS asse	ssment time frame for			week, x 2 weeks, and weekly x weeks, and monthly thereafter	
	mood.				and submitted to the CQI	,
					Committee for review and follo	ow
	A care plan with	a problem start date of			up to ensure all employees are	e
		d, "Resident has			knowledgeable about identifyii	
		des (Delusions) AEB [as			and reporting abuse unitl 100%	
	1 -	elieve staff refuse to			compliance is achieved.All sta were educated on Abuse	III
	1				Prevention and Reporting	
	_	nily does not visit, and			inservice on 9-25-12 with	
	_	ns] are to kill her rather			completion date of 9-30-12.Ho	ow
	than help her"				the corrective action will be	
					monitored to ensure the deficience	
	_	iew on 9/18/12 at 10:30			practice will not recur, ie: what quality assurance program wil	•
	a.m., the Admini	strator indicated during a			put into place?To ensure	
	review of Reside	ent #B's progress notes on			compliance, the DNS/designer	e is
	9/17/12 at 6:00 p	o.m., she discovered the			responsible for the completion	
	abuse allegation	made by the resident			the Abuse CQI tool weekly for	•
	documented in t	he progress notes dated			weeks, bi-monthly for 2 month adn then quarterly until continu	•
	9/17/12 at 3:13 p	o.m., which was entered			compliance is maintained for 2	
		ctical Nurse [LPN] #1.			consecutive quarters. The res	
		or indicated LPN #1 left			of these audits will be reviewe	d
	the facility with				by the CQI committee oversee	
	allegation to the	•			by teh E.D. If threshold of 100	
		rammonavor.			is not achieved an action plan be developed to ensure	WIII
	On 9/18/12 at 10	2:45 a.m., the progress			compliance.	
		nt #B were re-reviewed			-	
		w with the Administrator				
		1's entry to Resident #B's				
	record on 9/17/1	2 at 3:13 p.m.				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/19/2012	
	PROVIDER OR SUPPLIEF	RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD APOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	p.m., indicated, make negative simean and that wher. Did not renup in chair today states she's afrairesident and statin any way possiback." A facility invest date of 9/17/12 at the Administrate indicated, "Bri Incident: ED [Eviewing daily nufound statement nurses note statinher and that they and that she was investigation incompleted assistant [CNA] Resident #B who statements LPN progress notes date of 18/12, and initing Administrator in of CNA #2] whas statements from	#1 recorded in the ated 9/17/12 at 3:13 p.m. w with CNA #2, dated ialed by the dicated, "I asked [name at she thought the [name of Resident #B] e stated abuse and that the			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/01/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155149		ILDING	00	COMPL 09/19/	ETED	
	NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	titled, "Abuse Pr Investigation Po dated February 2 abuse allegations to the Executive is the responsibil American Senion only report abuse suspicion of abu	n 9/18/12 at 12:33 p.m., rohibition, Reporting, and licy and Procedure," 2010, indicated, "All s/abuse must be reported Director immediatelyIt lity of every employee of r Communities to not e situations, but also se and unusual I circumstances to his/her						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: \$51211

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